North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities
and Substance Abuse Services

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Richard Visinagrdi, Ph. D., Director

M E M O R A N D U M

TO: Area Directors
Hospital CEO's

FROM: Richard J. Visingardi, Ph.D., Director, DMH/DD/SAS
William Pulley, President, N.C. Hospital Association
Carol Duncan Clayton, Executive Director, N.C. Council
Of Community Programs

DATE: August 8, 2003

RE: Collaboration Protocol

As North Carolina proceeds with reform of its public mental health, developmental disabilities and substances abuse system, the rule of the local mental health authority will change. These authorities will shift from the role of services provider to that of public policy and service system manager. Also, the locus of service provision will continue to move from state run institutions to community providers. In view of the unique role that local hospitals play in serving people with mental illness, substance abuse problems and developmental disabilities, collaborations between local hospitals and area authorities is pivotal to the successful transformation of the public mental health system.

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We are happy to share with you the attached protocol, which we think can be a useful tool in facilitating collaborations. In the spirit of collaboration, this protocol was developed by committee comprised of representatives from local hospitals, area authorities and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

RJV/DW/bs
Attachment

cc: Carmen Hooker Odom
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North Carolina Hospitals

&

Local Management Entities

Collaboration Protocol

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Collaboration Protocol

Background

Local hospitals play a unique role in assisting area authorities/county programs, hereafter known as Local Management Entities (LMEs), to carry out their mission. To appreciate their importance, one only needs to consider the fact that the local hospital emergency room is, generally, the place where, by design or default, people in psychiatric crisis present. In view of this, collaboration between the local hospital(s) and the LME is critical to the success of mental health reform and good client care. As a means of facilitating communication and collaboration, a group of thirteen individuals representing local hospitals and LMEs met for the purpose of establishing a protocol to guide local discussions on key issues related to mental health reform and the general working relationship between local hospitals and LMEs.

Although mental health reform has provided the impetus for the development of this document, many of the issues addressed in the protocol are longstanding and predate mental health reform. However, the advent of reform creates a more compelling need to resolve these issues. It is imperative that the Division of Mental Health, Developmental Disabilities and Substance Services, local hospitals and LMEs establish mutual trust and working relationships that can be acknowledged when asking other key community stakeholders to help in resolving crucial systems issues.

Common Interests

Local hospitals and LMEs serve a public or quasi-public function, i.e., meeting the health/mental health needs of the residents of their respective communities. As such, the goodwill of the public is a commodity of significance. There is much that hospitals and LMEs can do jointly to benefit the people being served and enhance public goodwill. Among those things, the parties can work together to: increase customer satisfaction; insure staff and patient safety while improving access to emergency, inpatient and outpatient services; promote the efficient use and leverage of community resources; recruit and retain competent and satisfied professional staff; improve risk management strategies; and develop and/or expand business relationships. Developing trust and working to address these common interests requires a concerted and sustained effort.

The Process

The process and issues that follow are meant to guide and facilitate collaboration between LMEs and local hospitals.

The Invitation: Based upon a recognition of common interests, the parties at the local level must assume responsibility for creating opportunities for dialogue that will lead to the development of solutions to the issues. While change does not occur overnight, it can be effected over time through affirmation of common interests, surfacing local nuances to issues raised in this protocol, by encouraging learning and innovation, recognizing what is outside local control, and reaching consensus on solutions. The LME is encouraged to initiate the invitation to start the collaboration process, but the local hospital may also do so, depending on the particular need within the community.

The Convener: There are a number of methods that might be utilized, but it often helps to assign liaisons from each party to be accountable for managing the process, including developing agenda, insuring that key stakeholders are invited as key issues involve them, providing background materials, recording decisions and communicating the results to all stakeholders.

The Agenda: A solid agenda for a first meeting would be to establish a common objective and then to examine the local status of the issues listed in this document as well as identifying other issues that are relevant to the specific locality. It usually works best to establish a standing meeting time and a core of participants that can attend consistently.

The Participants: The core group should include those representatives of the parties that are authorized to speak on their behalf. Unless this authority exists, additional meetings are needed and results are impeded. The core group should also include ultimate customers, the persons likely to be served. Sometimes people with special expertise in a given issue are needed though not necessarily as regular participants. Core group participants could be chosen from among the following:

- ER managers
- Assessors
- LME triage
- Triage at Hospital
- Physicians
- LME Care Coordinators
- LME Utilization Manager
- LME Medical Director
- Consumer Representative of CFAC

The Issues:

What follows is a summary of issues in three distinct categories that LMEs and Hospitals can use to initiate dialogue: Awareness, Access/EMTALA, and Inpatient Care/Follow-up. In no way is it implied that these issues exist in each locale. Also, it is understood that these are general issues identified by consensus as being of concern in many areas of the State. This protocol is not dictating a solution to these issues, but rather is requesting local dialogue and consensus on resolution of those issues specific to the local area.

Awareness

- There are varying levels of understanding about mental health reform
- Information and education regarding the State Plan is not always provided to the stakeholders using language that is easily understood
- The DMHDDSAS has a responsibility to be a part of the discussion
- State Hospitals need to be at the table and all local hospitals within the LME's geographic area should be included in the process
- Issues should be explored and discussed from a variety of perspectives
- Generally, there is insufficient understanding of the regulatory environments within which hospitals and LMEs must operate
- Constant attention should be given to identifying and removing roadblocks to collaboration at the local level and referring statewide barriers to the Task Force that has been established by the Division, the NC Hospital Association and the NC Council
- Line staff of both the hospital and LME must be apprised of the cooperative efforts that are being undertaken by the two parties.

The Participants: In addition to the core group, representatives of the following interests should be involved in helping to develop solutions to some of the awareness issues:

- Division of MHDDSAS
- LME Administration
- Hospital Administration
- ER Physicians
- Law Enforcement
- Consumers

- CFAC
- County Administrators
- Private Providers
- Primary Care Physicians & Pediatricians
- Other related Stakeholders represented on local Collaboratives such as DSS

Access/EMTALA

- ERs, generally, do not have the capacity to respond in a timely manner when multiple persons present at the ER in need of a mental health evaluation
- People needing a mental health evaluation are presenting at ERs in increasing numbers
- Hospitals bear a specific risk under EMTALA that is not shared by other organizations in the community
- Streamlining of the State Hospital referral process needs to occur*
- There is a need for timely identification of non-state hospital inpatient resources, possibly through the development of a statewide bed availability system
- Community development of alternatives to inpatient care is needed
- Credentialing & privileging of LME staff by local hospitals
- Transportation is an issue that keeps people in ERs and inpatient units longer than necessary
- Some local hospitals won't take an individual without a transportation plan which can hold up admissions
- There needs to be consistency among State Hospitals regarding requirements for clearance for admission*
- Access to consumer crisis plans and current medications would help ERs making dispositions
- A local diversion process for persons with a co-morbid developmental disability is needed*
- The parties need to feel comfortable with the level of risk involved in a disposition decision and the safety of the setting a person is discharged to

- ERs are burdened due to the time required to stabilize intoxicated people prior to admission
- Law enforcement has resource contingencies that may prevent staying with people in the ER creating safety issues

***These issues have statewide implications and will also be addressed by the Division/Hospital Association/NC Council Task Force.**

The Participants: In addition to the core group, representatives of the following interests should be involved in helping to develop solutions to specific aspects of the Access/EMTALA issues:

- ER managers
- Assessors
- LME triage
- Triage at Hospital
- Physicians
- LME Care Coordinators
- LME Utilization Manager
- LME Medical Director
- Consumers
- CFAC
- Division and State Hospitals
- Planner from LME
- Crisis Response Staff/Providers
- Law enforcement local and county
- Providers
- Magistrate
- DMA (resources)

Inpatient Care / Follow up

- Agreed upon admission criteria must address safety-staffing issues
- Transition and coordination of care issues needs to be clear and acceptable across all providers
- Medications needed after discharge must be available
- Lack of housing at discharge can create unnecessary extended lengths of stay
- Some local hospitals do not take Involuntary Commitments
- A lack of care coordination pre admission and post discharge causes recidivism and increased risk
- A general lack of access to inpatient beds is due, in part, to a lack of attending physician and other issues
- There is a lack of medical-psychiatric beds
- Inappropriate referrals come from the criminal justice system
- Reimbursement rates for inpatient care need to be examined
- Discharge summaries are requested before transfer and cannot be completed within 24 hours
- The Hospital as provider/LME relationship needs to be strengthened

The Participants: In addition to the core group, representatives of the following interests should be involved in the development of solutions to specific aspects of the inpatient care issue:

Hospital and LME CEOs

- ER managers
- Physicians
- LME Care Coordinators
- LME Utilization Manager
- LME Medical Director
- Hospital social work staff
- Consumers

- CFAC Community
- EMS
- DSS
- IP Managers of Local Hospitals
- Law Enforcement
- Division and State Hospital Administration

BARRIER BUSTERS: Division, Hospital Association, NC Council Task Force

The Division, the Hospital Association and the Council of Community Programs established a task force that began meeting in November 2002. The Task force is charged, among other things, to facilitate collaboration at the state level and to address issues that have state-wide implications. Local collaborative work teams may submit issues of a state-wide nature to the Task Force. The deliberations of the Task Force will be published on the DMHDDSAS web site.

Participants

Mary Hill	Associate Vice Pres., Duke Univ. Health System
Karen Salacki	Area Director, Edgecombe-Nash Area Program
Jo Haubenreiser	Vice President, Novant Health System
William Nolan	Vice President, Novant Health System
Ron Morton	Area Director, CenterPoint Area Program
Carol D. Clayton	Executive Dir., NC Council of Community Programs
Janet Nottingham	Wilson Medical Center
Sam Pittman	Manager of Triage, Coastal Plain Hospital/Nash Health System
Mike Vicario	Vice President, Regulatory Affairs, NC Hospital Association
Tom McDevitt	Area Director, Smoky Mountain Area Program
Doug Trantham	Smoky Mountain Area Program
Ellen Holliman	Area Director, Durham Area Program
Don Willis	Chief, Administrative Support DMH/DD/SAS
Chris Thompson	Consultant